

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be directed to use on the burial/transit permit. Then please remove carbon papers. Post, and send to the State Dept. of Health and Mental Hygiene prior to burial/cremation. In removal of the State Dept. of Health and Mental Hygiene stamp, the medical examiner's stamp should be affixed.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner's stamp should be affixed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										6	0	2	9	2	9
										REG. NO.					
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		GEORGE		ALBERT		ABELL				January 8, 1986		9:36 P M			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH		DAY	YEAR	84		YRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		USA		<input type="checkbox"/>		<input type="checkbox"/>		St. Mary's County		MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Leonardtown		St. Mary's Hospital													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
Md.		St. Mary's		California		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Star Route Box 103							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST						
		George	Franklin	Abell			Alice	Victoria	Hammett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No		217-30-0744		Beatrice Abell Combs		Same as 13e.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Hypoxemia → cardiac arrest															
DUE TO, OR AS A CONSEQUENCE OF (b) Esopatium pneumonia															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did) (did not) view the body after death.															
22b. SIGNATURE <i>Fenwick</i>										DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-9-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Leonardtown, Maryland 20650											
John F. Fenwick, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		1/11/86		St. Johns Cemetery		Hollywood, St. Mary's		Md.							
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.										25a. DATE REC'D. BY REGISTRAR JAN 13 1986		25b. REGISTRAR'S SIGNATURE <i>Susan Anderson Pendell</i>			

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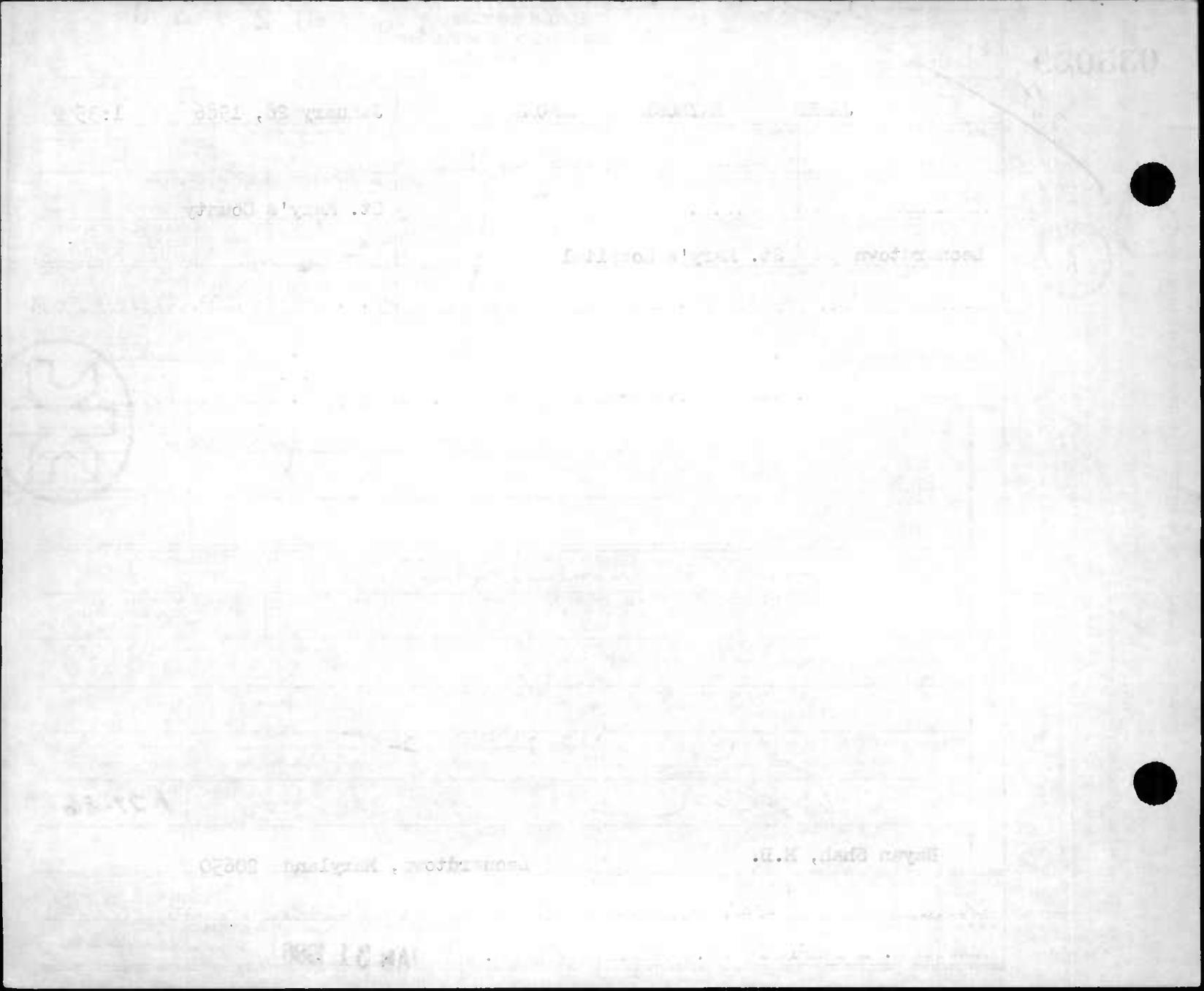
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 more be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 8 6 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 2 9 3 0							
1. DECEDENT'S NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			REG. NO.								
JAMES RAYMOND ARNOLD																	
2. SEX MALE			3. RACE WHITE			4. DATE OF BIRTH JULY 1, 1922			5. DATE OF DEATH January 28, 1986								
6. BIRTHPLACE COUNTRY VIRGINIA			7. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (IN YEARS LAST BIRTHDAY) 63 YRS								
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARTOGRAPHER			12b. KIND OF BUSINESS OR INDUSTRY NAVY DIV. CIVIL SERVICE								
13. STATE MARYLAND			13b. COUNTY ST. MARY'S			13c. CITY OR TOWN ST. INIGOES			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE P.O. BOX 4, JUTLAND ROAD 20684				
14. FATHER'S NAME FIRST RAYMOND			MIDDLE B.			LAST ARNOLD			15. MOTHER'S MAIDEN NAME FIRST HELEN				MIDDLE L.		LAST STEVENS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. W.W.II			17. INFORMANT MARILYN D. ARNOLD, ST. INIGOES, MARYLAND			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			(b)			DUE TO, OR AS A CONSEQUENCE OF											
			(c)			DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Aspiration pneumonia</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <i>1/28/86</i> , 19 <i>86</i> , to <i>1/29/86</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>1/28/86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) not view the body after death.																	
22b. SIGNATURE <i>R. Shah</i>										22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nayan Shah, M.D.							
22e. ADDRESS Leonardtown, Maryland 20650										22f. DATE SIGNED <i>1-29-86</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 1/29/86			23c. NAME OF CEMETERY OR CREMATORIAL HUNT CREMATORIAL			23d. LOCATION CITY OR TOWN WALDORF, COUNTY CHARLES, STATE MARYLAND								
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.									25a. DATE REC'D. BY REGISTRAR JAN 31 1986				25b. REGISTRAR'S SIGNATURE <i>Edward N. Brinsfield</i>				
DHMH - 16 60M 7/84 (VRA 15, 4)																	



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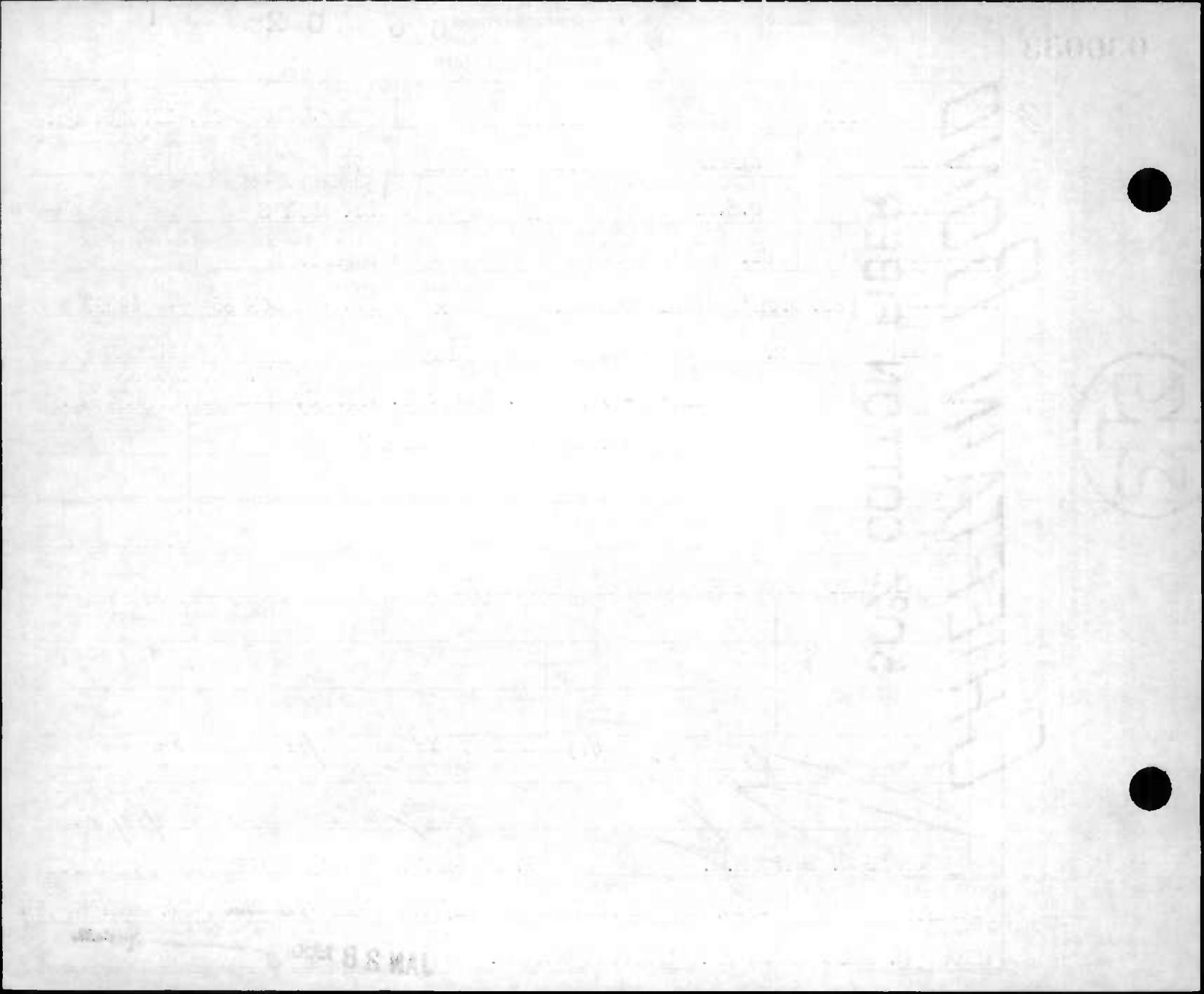
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8602931

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
MARY HELEN BARNES						JANUARY 19, 1986	8:29 a.m.							
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)								
FEMALE		BLACK	MONTH	DAY	YEAR	74	IF UNDER 1 YEAR		IF UNDER 24 HRS					
70. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.							
MARYLAND		U.S.A.												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
LEONARDTOWN		ST. MARY'S NURSING HOME			HOMEMAKER									
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S	13c. CITY OR TOWN LEXINGTON PK.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RT. #4, BOX 33 20653							
14. FATHER'S NAME FIRST JOHN		MIDDLE R.	LAST SOMMERSVILLE	15. MOTHER'S MAIDEN NAME ALICE			LAST BROOKS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT MR. THOMAS T. BARNES, LEXINGTON PARK, MD.			ADDRESS RT. #4, BOX 33						
NO		216-09-0705												
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CEREBROVASCULAR ACCIDENT														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.														
b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 CHRONIC RENAL INSUFFICIENCY, HYPERTENSION														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> 41 WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (i) (this hospital) attended the deceased from 11/19, 1987, to 1/18, 1988, that (i) (we) last saw the deceased alive on 1/19, 1988, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.														
22b. SIGNATURE														
22c. DEGREE														
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22d. PHYSICIAN'S NAME (110 DEGREES)		22e. ADDRESS			22f. DATE SIGNED 1/19/88									
JAMES C. BOYD, M.D.		17 JEFFERSON STREET, LEONARDTOWN, MARYLAND												
23a. BURIAL, CREMATION, REMOVAL 12PCP#1 BURIAL		23b. DATE 1/22/86		23c. NAME OF CEMETERY OR CREMATORIAL IMMACULATE HEART/MARY			23d. LOCATION CITY OR TOWN LEXINGTON PARK, COUNTY ST. MARY'S, STATE MD.		25a. DATE REC'D. BY REGISTRAR JAN 28 1986				25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.														
DHMH - 16 60M 7/84 (VRA 15, 4)														



029143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, given to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

02932

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
JULIA MAE BOWLES			JANUARY 21, 1986 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS	IF UNDER 1 YEAR HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Lexington Pk.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Amber House	
13a. STATE Maryland			13b. COUNTY St Mary's	
13c. CITY OR TOWN St Mary's City			13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
? Adams			? Stone	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 218-54-8904	17. INFORMANT Mary R. Kohut	ADDRESS same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for item 18, Part 1) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> IN <u>wk</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal DE</u> IN <u>months</u> DUE TO, OR AS A CONSEQUENT OF (c) <u>Atherosclerosis</u> IN <u>yes</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>1986</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>1/20/86</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.				
22b. SIGNATURE <u>James P. Jarboe M.D.</u> DEGREE <u>MD</u>				
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. ADDRESS <u>Leonardtown, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 24, 1986	23c. NAME OF CEMETERY OR CREMATORIAL St Aloysius	23d. LOCATION CITY OR TOWN Leonardtown, Maryland
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtown, Maryland	25a. DATE REC'D. BY REGISTRAR JAN 27 1986	25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell

661850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

Film G612 item 16b 2/25/86 rja

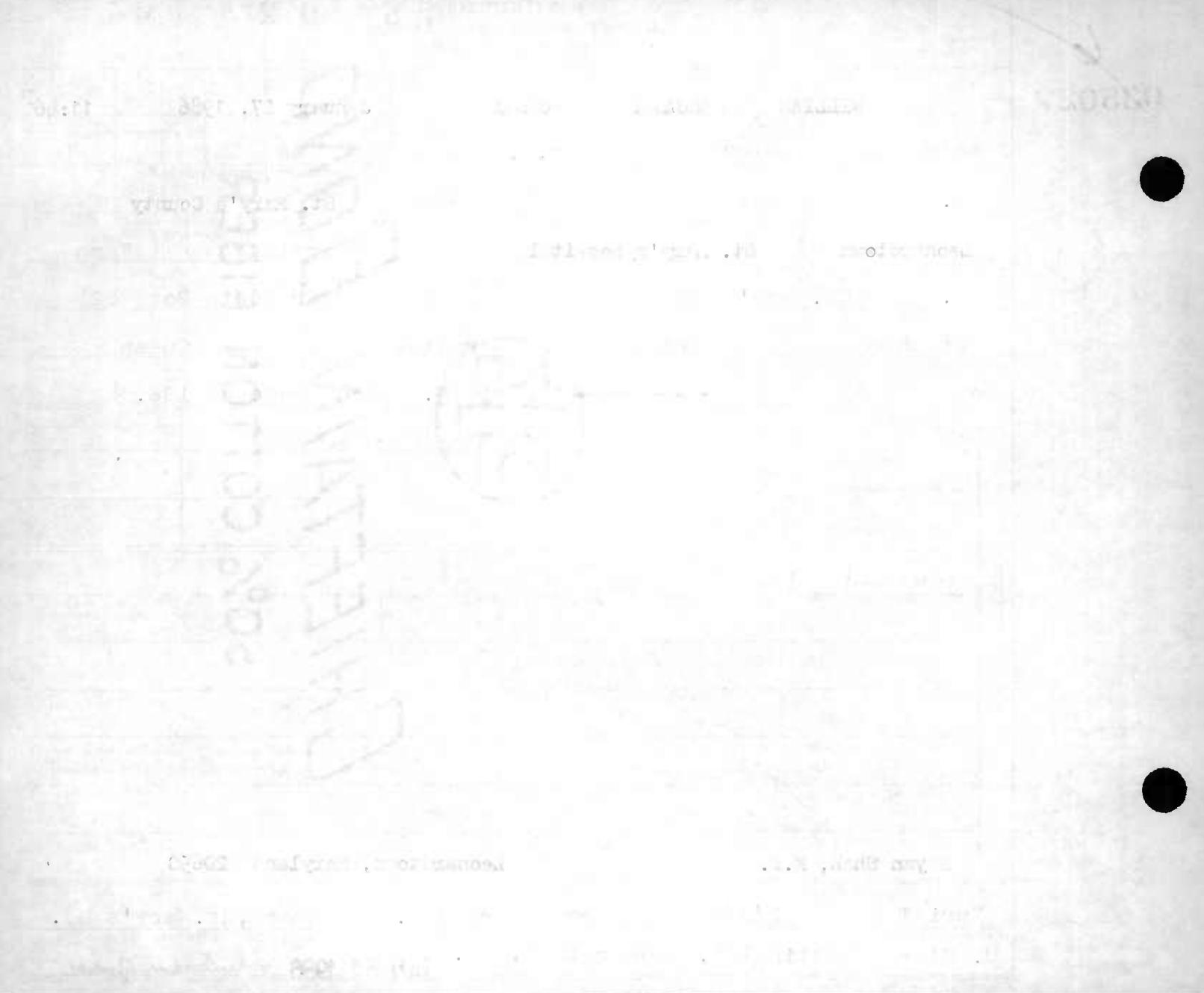
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

36 02933

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
WILLIAM WALTER BOWMAN						January 27, 1986				11:46 P			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		Black		Dec. 1, 1919		66		MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Md.		USA				St. Mary's County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Leonardtown		St. Mary's Hospital				Farming		Farm					
13a. STATE Md.						13b. COUNTY St. Mary's		13c. CITY OR TOWN Maddox		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Star Route Box 262	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Stephen Bowman						Caroline Queen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		220-05-3229 214-48-9821		Marie M. Bowman		Same as 13e.							
18. CAUSE OF DEATH (Enter only one cause per line for 1d, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Multiple Myeloma													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Renal Failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) see the body after death.													
22b. SIGNATURE						DEGREE							
						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
Nayan Shah, M.D.						Leonardtown, Maryland 20650							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Burial		2/3/86		Sacred Heart Cem.		Bushwood, St. Mary's Md.							
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
W. Clarke Mattingley, Leonardtown, Md.						JAN 31 1986		Seth Davidson Pendleton					



009187

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8/6 02934

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
James Edward Carter						January 4, 1986					M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		Black		July 27, 1927		58		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Va.		USA				St. Mary's						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Lexington Park		Home						Saw Mill Worker		20653		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Md.		St. Mary's		Lexington Park		No <input type="checkbox"/>		P.O. Box 1274				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS				
Unknown						Unknown		Same as 13e.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.												
16a. No 16b. 228-22-4207												
17. INFORMANT Florence Marie Stewart												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any. <i>minutes</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Seizure Disorders</i> <i>minutes</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Seizure Disorders</i> <i>years</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 19 83, to 19 86, that (I) (we) last saw the deceased alive on 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.												
22b. SIGNATURE <i>J. Patrick Jarboe, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/6/86						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Patrick Jarboe, M.D.		22e. ADDRESS Leonardtown, Md. 20650										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/8/86		23c. NAME OF CEMETERY OR CREMATORIAL Charles Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtown, St. Mary's Md.						
24. FUNERAL DIRECTOR W. Clarke Mattingley		ADDRESS Leonardtown, Md.		25a. DATE REC'D. BY REGISTRAR JAN 7 1986		25b. REGISTRAR'S SIGNATURE <i>John Larson-Parker</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3  
relied on by the hospital or attending physician.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



REG. NO.

2935

029114

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3, RETAIN PAGE 5 FOR YOUR PAGES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE HELD WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 N. PRESTON STREET, BALTIMORE, MARYLAND, 21202, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS 201 W PRESTON ST. BALTIMORE, MD. 21201

DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		XX MONTH DAY YEAR		2b. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		1-19 19 86					
Male		Black		Nov. 30, 1952		33 yrs.		MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		<input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA		WIDOWED		DIVORCED		<input type="checkbox"/>		St. Mary's County,			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Mechanicsville		Box 444, Rt. 6		Farmer		Tobacco							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				20659	
Maryland		St. Mary's		Mechanicsville		No		Rt. 4, Box 387					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Albert				Holt		Jane		I		Dotson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes				burned in fire		Jane I. Dotson		Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Thermal Injuries													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		5:40XX 1-19 1986		subject recovered from burned trailer									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN							
		Home		Box 444, Rt. 6, Mechanicsville		St. Mary's Co., Md.							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion					
death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		Jan. 25, 1986		Charles Memorial		Leonardtown, St. Mary's, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
W. Clarke Mattingley		Leonardtown, Maryland		JAN 27 1986		Gina Dawson							

07/84  
25M

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))

DHMH - 17  
(VR A15 ME (5))

07/84  
25M

111030

016052

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02936

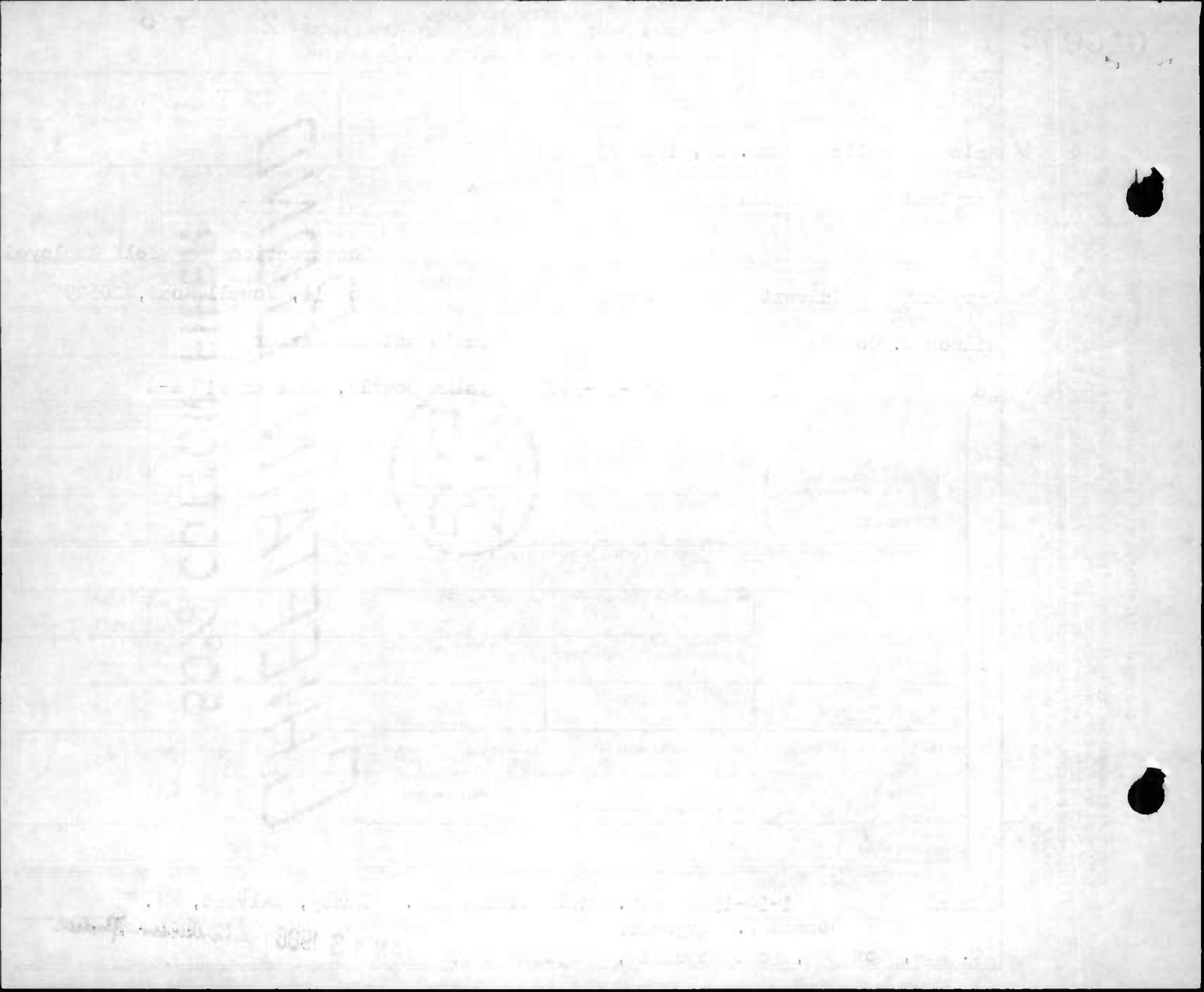
1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST CHARLES	MIDDLE Owen	LAST DOWELL	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/>	MONTH 1	DAY 7	YEAR 1986	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 25, 1912 73	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONONCED DEAD <input checked="" type="checkbox"/>	MONTH 1	DAY 7	YEAR 1986	2d. HOUR 1:04 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD				
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Dowell		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS Box 11, Dowell Road, 20629		
14. FATHER'S NAME FIRST Wilson W. Dowell		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST Sadie Estelle Garner		MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		16c. ADDRESS 214-16-7003		17. INFORMANT Velma Dowell, Same as #13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>										
23a. ACTUAL SIGNATURE <u>Ann M. Dixon, M.D.</u>										
23b. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										
23c. DATE SIGNED 1-8-86										
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., MD 21201								
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23e. DATE 1-10-1986		23f. NAME OF CEMETERY OR CREMATORIAL St. Pauls Church Cem.		23g. LOCATION CITY OR TOWN Lusby, Calvert, Md. COUNTY STATE				
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt ADDRESS Rt. 264, Box 34B, Port Republic, Maryland 20676		25a. DATE REC'D. BY REGISTRAR JAN 13 1986 25b. REGISTRAR'S SIGNATURE <u>Jeanne Davidson Pendleton</u>								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 11-13. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHHM - 17  
(VR A15 ME (5))



029030

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

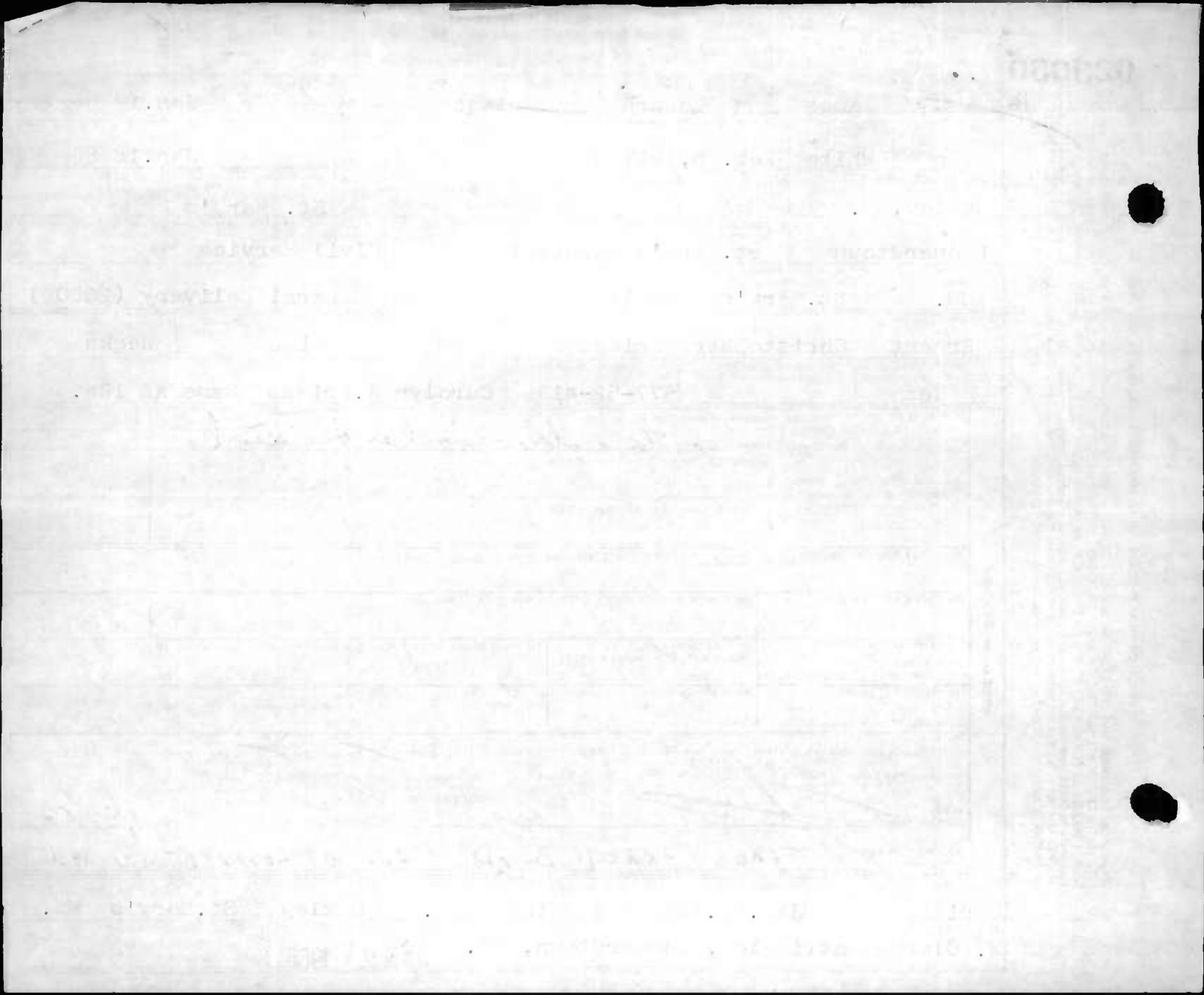
REG. NO. 02937

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST James	MIDDLE Howard	LAST Friess	2a. DATE KNOWN OF ESTI- MATED DEATH	MONTH Jan. 18	DAY 19	YEAR 86	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Feb.	DAY 6, 1927	YEAR 58 YRS. *LAST BIRTHDAY	6. AGE (IN YEARS) IF UNDER 1 YR. MONTHS IF UNDER 24 HRS. DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD Jan. 18, 1986	MONTH Jan. 18, 1986	DAY 19	YEAR 86	2d. HOUR M
7a. BIRTHPLACE ESTATE OR FOREIGN COUNTRY Oakley, Md.		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's				
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service			12b. KIND OF BUSINESS OR INDUSTRY	
10a. STATE Md.	13b. COUNTY St. Mary's	13c. CITY OR TOWN Abell	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS General Delivery (20606)				
14. FATHER'S NAME FIRST Ernest			MIDDLE Christopher	LAST Friess	15. MOTHER'S MAIDEN NAME FIRST Ada			MIDDLE Lee	LAST Weeks	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 577-52-4195			17. INFORMANT Carolyn J. Friess			ADDRESS Same as 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anterior cerebrovascular accident</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>James Carroll</i> M.D. MEDICAL EXAMINER										
TITLE (SPECIFY)										
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS JAMES CARROLL Box D Box 301 LEONARDTOWN MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 21, 1986			23c. NAME OF CEMETERY OR CREMATORIAL All Saints Cem.			23d. LOCATION CITY OR TOWN Oakley	
24. FUNERAL DIRECTOR W. Clarke Mattingley			ADDRESS Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR JAN 27 1986			25b. REGISTRAR'S SIGNATURE <i>James Carroll</i>	



021088

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 6 0 2 9 3 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place in the Health and Mental Hygiene prior to burial, cremation, or removal, with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR										
1. DECEASED NAME (TYPE OR PRINT)			LAST			12b. HOUR							
GEORGE ALOYSIUS GARNER			January 12, 1986			12:05A							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
MALE		BLACK		SEPT. 27, 1919		66							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
MARYLAND		U.S.A.				St. Mary's							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown		St. Mary's hospital		MAINTENANCE MAN									
13a. STATE MARYLAND				13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEXINGTON PK.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. #3, BOX 273 20653			
14. FATHER'S NAME FIRST GEORGE				MIDDLE A.		LAST GARNER		15. MOTHER'S MAIDEN NAME FIRST ALICE		MIDDLE EDNA		LAST BARBER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 219-16-1691A		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH minutes		ADDRESS 654 DUMBARTON AVE.			
						MRS. ALICE L. JOHNSON, BALTIMORE, MD. 21218							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure													
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Myopathy													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (He/She) attended the deceased from 19 75 to 11 12, 19 86 that (I) (He/She) last saw the deceased alive on 19 86, and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated above, (I) (He/She) did not see the body after death.													
22b. SIGNATURE James P. Jarboe, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James P. Jarboe, M.D.		22e. ADDRESS Leonardtown, Maryland 20650											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/15/86		23c. NAME OF CEMETERY OR CREMATORIAL IMMACULATE HEART/MARY		23d. LOCATION CITY OR TOWN LEXINGTON PARK, ST. MARY'S, MD.		23e. STATE MD.					
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		25a. DATE REC'D. BY REGISTRAR JAN 17 1986		25b. REGISTRAR'S SIGNATURE Randall									

68150

Montgomery

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3

should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death

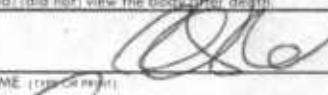
with the State Dept. of Health and Mental Hygiene. Prior to burial, cremation or removal

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other foul smell, event, the medicare examiner must be notified at once.

010074

1 - STATE  
REGISTRARSTATE OF MARYLAND 8 6  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 02939

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
JOSEPH ALOYSIUS GREENWELL						January 1, 1986				12:33PM	
3 1. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		May 22, 1935		50		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County		MD.			
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13. STATE Md.		13b. COUNTY St. Mary's		13c. CITY OR TOWN Hollywood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt. 3, Box 729-20634			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Joseph		Frederick		Greenwell		Emily				McGee	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		578-44-0515		Frances Louise Gatton		Same as 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe pulmonary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>oedema</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Congestive heart failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (II) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED JAN 8 1986	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		Nayan Shah, M.D.		Leonardtown, Maryland 20650					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/4/86		23c. NAME OF CEMETERY OR CREMATORIY St. Johns Cemetery		23d. LOCATION CITY OR TOWN Hollywood, St. Mary's Md.		23e. COUNTY Md.		23f. STATE Md.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 8 1986		25b. REGISTRAR'S SIGNATURE 					

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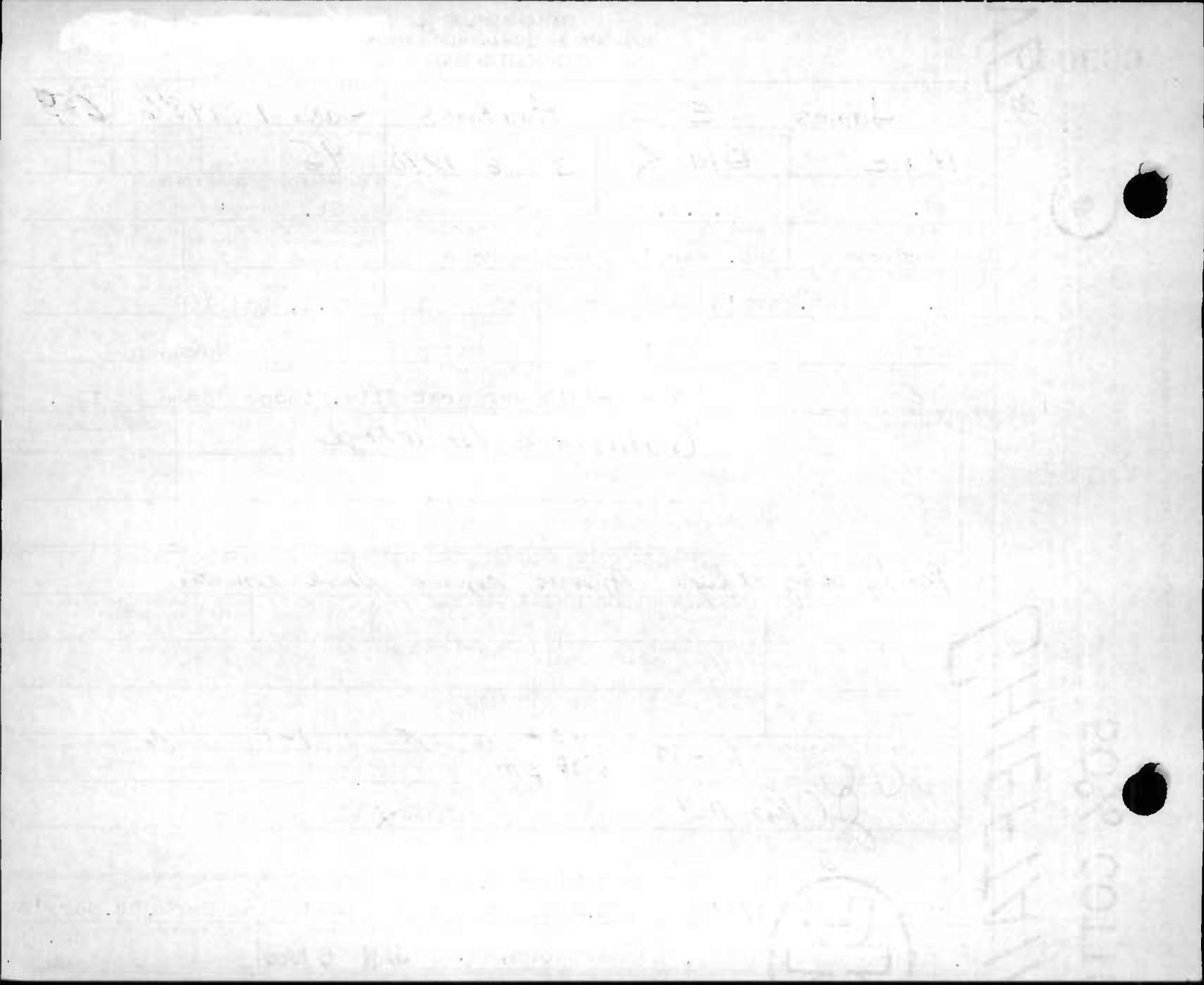
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 8 6 0 2 9 4 0 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO.											
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY		YEAR
1. DECEASED NAME (TYPE OR PRINT)			FIRST			LAST			2b. HOUR		
James Ernest Hawkins									6:58 M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Male			Black			MONTH DAY YEAR			IF UNDER 1 YEAR		
7. BIRTHPLACE COUNTRY			8. CITIZEN OF WHAT COUNTRY?			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10. BALTIMORE CITY OR COUNTY OF DEATH		
Md.			U.S.A.						St. Mary's		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Leonardtown			St. Mary's Nursing Home						MD.		
13a. STATE Md.			13b. COUNTY St. Mary's			13c. CITY OR TOWN Lexington Park			13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST			LAST			15. MOTHER'S MAIDEN NAME FIRST			13e. STREET ADDRESS Rt. 1, Box 168 20653		
Thomas			Hawkins			Betty			MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			578-09-3213			Margaret Eliz. Biscoe			Same as 13e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular hemorrhage</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Pathology of lung. Arterio venous. Small dementia</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-86</i> to <i>1-1-86</i> , that (I) (we) last saw the deceased alive on <i>1-1-86</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>J. C. Ross MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. C. Ross MD</i>			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1/4/86			23c. NAME OF CEMETERY OR CREMATORIAL St. James Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Lexington Park, St. Mary's		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR JAN 6 1986			25b. REGISTRAR'S SIGNATURE <i>J. C. Ross MD</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be reigned by the funeral director, physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled by the funeral director, page 4 must be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 24 hours after the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If Item 21 is marked (1) item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 8602941 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
JOSEPH LEONARD HAYDEN Jr.						Jan 25, 1986			8:40 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		May 29, 1922			63						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Baltimore, Md.		USA					St Mary's						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Laurel Grove		at home											
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland		St Mary's		Laurel Grove			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20659 Rt. 1, Box 85 Mechanicsville			
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE LAST			
Joseph		Leonard		Hayden			Verna			Wood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
Yes WW11				Navy 577-24-8403				Nellie T. Hayden				Rt. 1, Box 85 Mechanicsville, Md.	
18. CAUSE OF DEATH: Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Insipidus</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any												DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intracerebral Extentension</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Epidemoid Carcinoma of Nasopharynx</u>												6 months 5 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on <u>Jan 21</u> 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) did (did not) view the body after death.													
22b. SIGNATURE <u>John Roache M.D.</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>25 Jan 86</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Roache M.D.		22e. ADDRESS Mechanicsville, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 26 1986		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		23d. LOCATION CITY OR TOWN Suitland, P.G. Maryland		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley		ADDRESS Leonardtown, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 31 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>							



016038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 02942

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST WOODROW	MIDDLE THOMAS	LAST HILL SR.	2a. DATE OF DEATH January 8, 1986	MONTH JAN	DAY 8	YEAR 1986	2b. HOUR 11:37 A.M.							
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH Feb. 26, 1917			DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hollywood, Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County			MD.					
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			20636					
13a. STATE Md.			13b. COUNTY St. Mary's			13c. CITY OR TOWN Hollywood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 546					
14. FATHER'S NAME FIRST George			MIDDLE Washington			LAST Lafayette Hill			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Louise			LAST Mattingly		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-16-3209			17. INFORMANT Rosie J. Hill			ADDRESS Same as 13e.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>																	
DUE TO, OR AS A CONSEQUENCE OF (b) _____																	
DUE TO, OR AS A CONSEQUENCE OF (c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Myocardial infarction, upper gastrointestinal bleeding</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) _____ the body after death.																	
22b. SIGNATURE <i>Yayan Shah, M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED JAN 13 1986								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yayan Shah, M.D.			22e. ADDRESS Leonardtown, Maryland 20650														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/11/86			23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery			23d. LOCATION CITY OR TOWN Hollywood, St. Mary's Md.			23e. COUNTY St. Mary's		23f. STATE Md.			
24. FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, Md.			25a. DATE REC'D. BY REGISTRAR JAN 13 1986			25b. REGISTRAR'S SIGNATURE <i>John J. Mattingley</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event the medical examiner must be notified.

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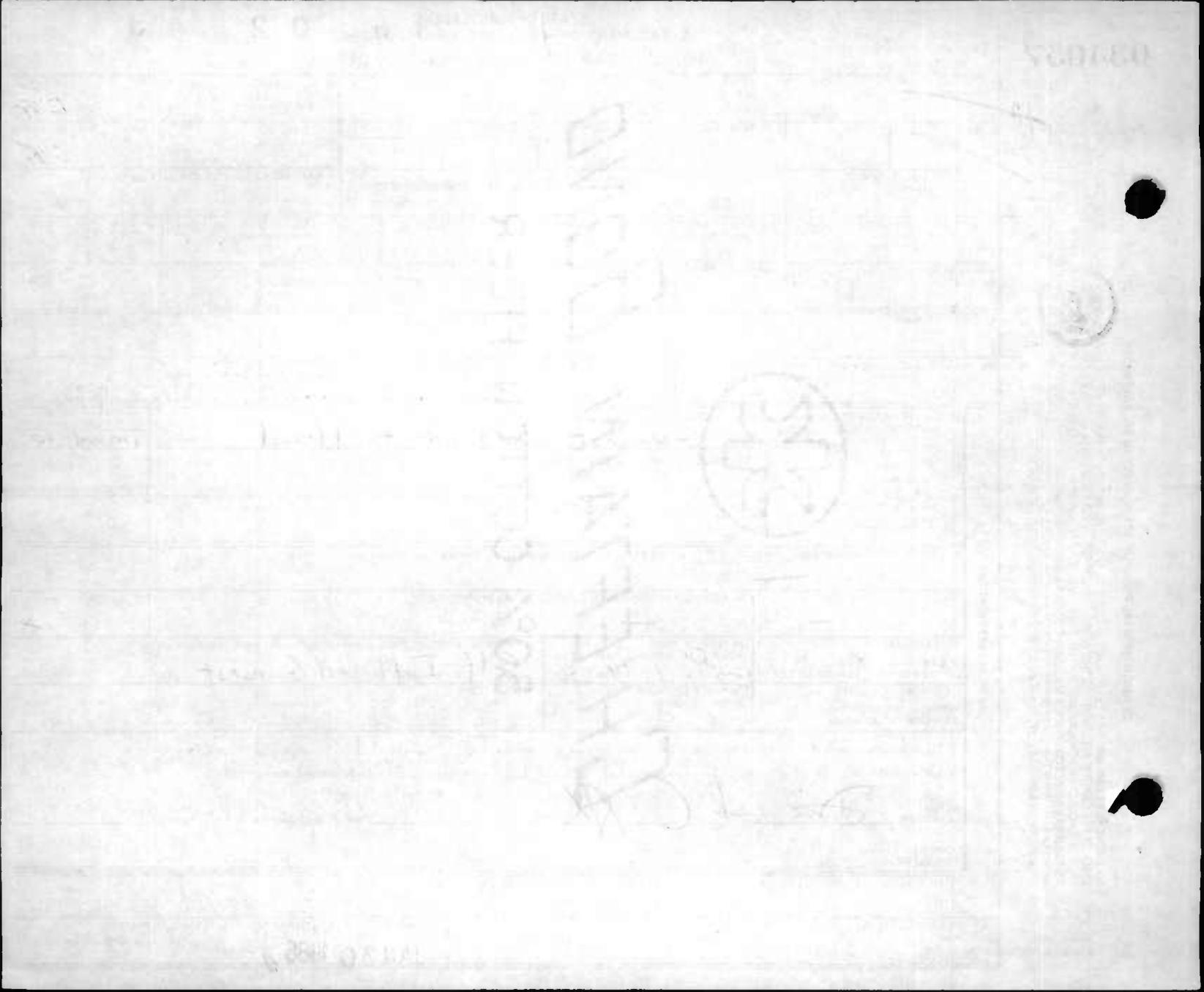
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1-  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
BERNARD ANTHONY KING						<input checked="" type="checkbox"/>				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE Pronounced DEAD	MONTH	DAY	YEAR	2d. HOUR
MALE	WHITE	APRIL 1, 1917	68 yrs.			JANUARY 24, 1986				12:00 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
WASHINGTON, D.C.		U.S.A.			ST. MARY'S					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
DAMERON		BAY FORREST ROAD P.O. BOX 88			MECHANIC			AUTO		
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN DAMERON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS BAY FORREST ROAD, P.O. BOX 88		20628		
14. FATHER'S NAME FIRST FRANCIS		MIDDLE HENRY		LAST KING	15. MOTHER'S MAIDEN NAME FIRST CLARA		LAST DORR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-01-4890			17. INFORMANT NEVA C. KING, DAMERON, MARYLAND 20628		BAY FORREST ROAD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		GUNSHOT WOUND TO HEAD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>		DUE TO, OR AS A CONSEQUENCE OF								
(b)		DUE TO, OR AS A CONSEQUENCE OF								
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a):										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 12:05 P.M. 1 24 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) SELF INFILCTED GUNSHOT					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) AT HOME			21f. LOCATION STREET P.O. 88 CITY OR TOWN BAY FORREST ROAD, DAMERON, ST. MARY'S, MD.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		DAVID C. ALLEN, M.D.			TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		DAVID C. ALLEN, M.D.			ADDRESS LEONARDTOWN, MARYLAND 20650					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 1-27-86		23c. NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN			23d. LOCATION CITY OR TOWN BRENTWOOD, PRINCE GEORGE, MD.		COUNTY STATE	
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR.		ADDRESS LEONARDTOWN, MARYLAND		25a. DATE REC'D. BY REGISTRAR JAN 30 1986			25b. REGISTRAR'S SIGNATURE JUNIOR BRINSFIELD			



021005

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR RECREMATION.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 02944  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR			REG. NO.													
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH MATED			2b. HOUR	
EARL			LEROY			KIGHT						1/7 1986			A M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR		
MALE		WHITE		NOV. 22, 1923			62				1/10 1986			2:10 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. MARRIED NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
NEW JERSEY		U.S.A.								ST. MARY'S						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
LEXINGTON PARK			RUE PURCHASE ROAD						SUPERINTENDENT			BELL TELEPHONE				
13a. STATE MARYLAND			13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEXINGTON PK.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. BOX 38L			20653			
14. FATHER'S NAME EARL			MIDDLE LEROY		LAST KIGHT			15. MOTHER'S MAIDEN NAME EMMA			LAST GETHENNS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		16c. SOCIAL SECURITY NO. 180-16-3783			17. INFORMANT BRUCE R. KNIGHT, 3 PLEASANT DRIVE LEXINGTON PARK, MD. 20653			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). _____																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) M.D. _____ MEDICAL EXAMINER																
ACTUAL SIGNATURE _____ DATE EXAMINER'S NAME (TYPE OR PRINT) JAMES C. BOYD, M.D. SIGNED 1/13/86																
17 JEFFERSON ST., LEONARDTOWN, MD.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. PLACE OF BURIAL OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
BURIAL			1/16/86			MARYLAND CHELTENHAM VETERANS			CHELTENHAM, PRINCE GEORGES, MD.							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.						IAN 17 1986										

CONTINUE

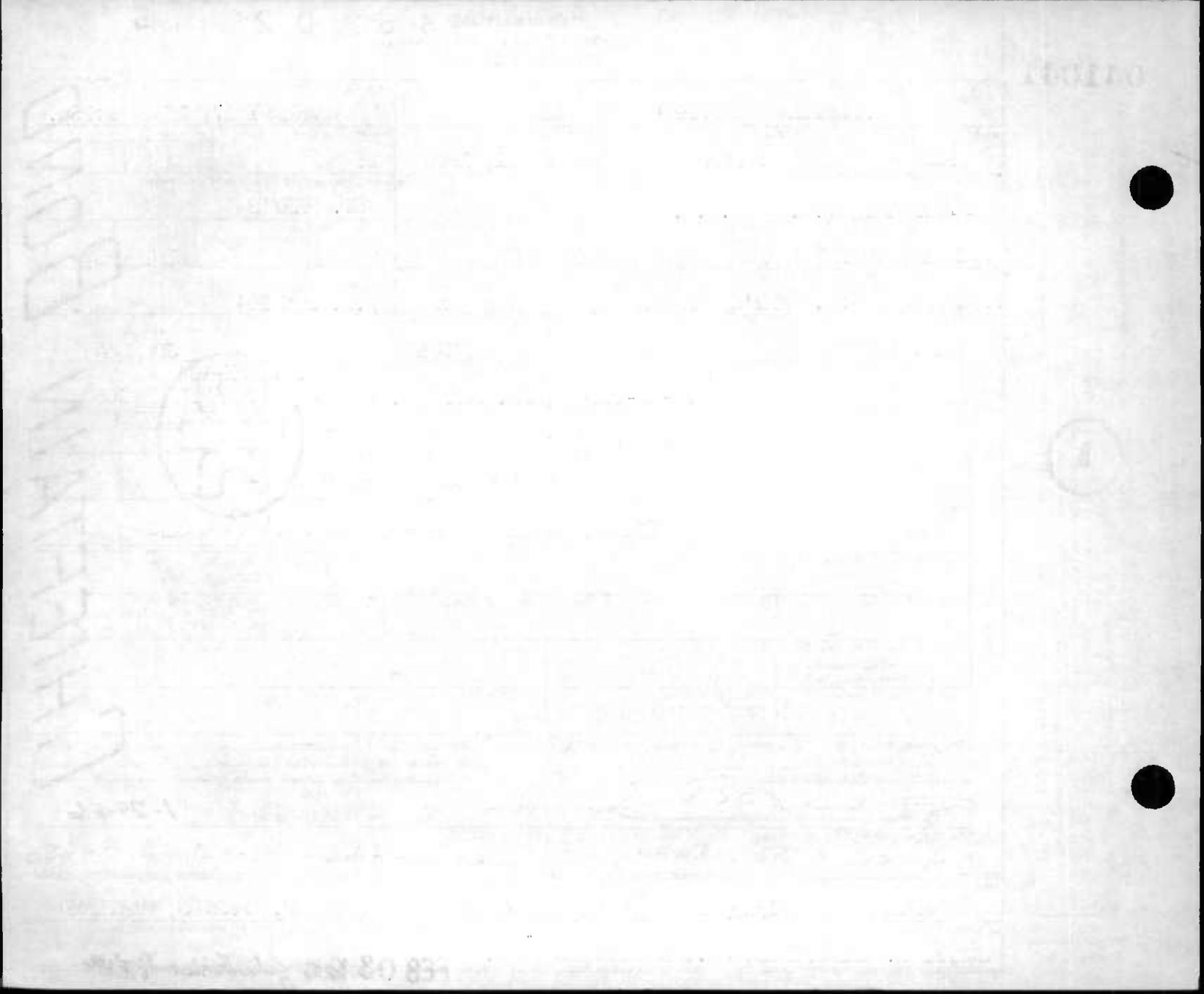
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please return certificate, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

041041

STATE OF MARYLAND 8 6 0 2 9 4 5 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
REG. NO.																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MAURICE			BERNARD			LEE						JANUARY 27, 1986				9:15p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
MALE		BLACK		AUGUST 31, 1900			85		YRS.		MONTHS DAYS HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
WASHINGTON, D.C.		U.S.A.					ST. MARY'S										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
LEXINGTON PARK		AMBER HOUSE NURSING HOME										TAILOR		CLOTHING			
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN ABELL			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. BOX 104			20606					
14. FATHER'S NAME FIRST UPSHUR		MIDDLE			LAST LEE		15. MOTHER'S MAIDEN NAME FIRST MARGARET		MIDDLE			LAST JOHNSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			17. ADDRESS P.O. BOX 104		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		578-05-6364					MRS. PEARL M. LEE, ABELL, MARYLAND 20606		hepatitis				Cirrhosis of liver				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				19c. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							19d. DUE TO, OR AS A CONSEQUENCE OF Diseases, conditions, or external causes contributing to death					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/24/86 19 to 1/29/86 19, that (I) (we) last saw the deceased alive on 1/24/86 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 1-29-86					
22b. SIGNATURE 		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/>			22e. MEDICAL DIRECTOR <input type="checkbox"/>		22f. STAFF PHYSICIAN <input type="checkbox"/>							
22g. PHYSICIAN'S NAME (TYPE OR PRINT)		22h. ADDRESS Leonardtown, Maryland 20650															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1/29/86			23c. NAME OF CEMETERY OR CREMATORIAL HUNTT CREMATORY			23d. LOCATION CITY OR TOWN WALDORF, CHARLES, MARYLAND		23e. COUNTY		23f. STATE					
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.								25a. DATE REC'D. BY REGISTRAR FEB 03 1986		25b. REGISTRAR'S SIGNATURE 							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

023052

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 0 2 9 4 6	
DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
JOSEPH		L.	LUBIN				January 17, 1986					9:22 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 6 YEAR 1906			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Austria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.								
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel									
13a. STATE Maryland		13b. COUNTY St. Mary		13c. CITY OR TOWN Scotland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Chesapeake Dr.-Rodo Beach 20687							
14. FATHER'S NAME FIRST Ludwig		MIDDLE	LAST Lubin	15. MOTHER'S MAIDEN NAME FIRST Tekla		MIDDLE	LAST Not Known								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 376-03-2336		17. INFORMANT Donald L. Lubin		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) (c) DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory Failure Pneumonia Carcinoma of lung		ADDRESS Same as 13e						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH not 1wk 6-7 mo	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1985</u> to <u>1/17</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.															
22b. SIGNATURE J. Patrick Jarboe, M.D.		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 1/17/86									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. Patrick Jarboe, M.D.		22f. ADDRESS Leonardtown, Maryland 20650		23a. BURIAL, CREMATION, REMOVAL (SPEC#) Burial		23b. DATE 1/20/1986		23c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus		23d. LOCATION CITY OR TOWN Baltimore		COUNTY STATE Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, Maryland 21222		25a. DATE REC'D. BY REGISTRAR JAN 21 1986		25b. REGISTRAR'S SIGNATURE J. Patrick Jarboe											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please return the remains to the funeral director or to the medical examiner if any injury or other information is present. The medical examiner should be notified once the remains are received.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other information, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND 8 6 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										02947						
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME			FIRST		MIDDLE		LAST		2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR	
RUTH			CECELIA		PAYNE				January 9, 1986						2:25 P M	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			Caucasian		MONTH DAY YEAR		86			MONTHS	YEARS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
New Jersey			USA							St. Mary's County MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Leonardtown			St. Mary's Hospital		Homemaker			Own Home								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
MD			Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2022D Wedgwood Place A 0601						
14. FATHER'S NAME			FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME									
Frederick J.					Danielson		Agusta									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS								
No			578-36-8453		son			3743 Donnell Dr.,								
18. CAUSE OF DEATH (Enter only one cause per line for Part I and II)			19. PART I. DEATH WAS CAUSED BY:			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
			IMMEDIATE CAUSE (a)			Respiratory Failure hours.										
			DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the Lung													
			DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/9/86 to 1/9/86, that (I) (we) last saw the deceased alive on 1/9/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 1/10/86.						
22b. SIGNATURE Terry Boyd, M.D.			22d. DEGREE II					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 1/10/86.						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Boyd, M.D.								23a. ADDRESS Leonardtown, Maryland 20650								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/11/86		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial			23d. LOCATION CITY OR TOWN Waldorf		COUNTY Charles	STATE MD	25a. DATE REC'D. BY REGISTRAR JAN 13 1986				
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, MD								25b. REGISTRAR'S SIGNATURE John Hunter, Jr.								

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0800 27/7/68

0801 27/7/68

0801 27/7/68

0801 27/7/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 should be detached to use on the burial permit. Then please remove carbon paper. Page 3 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, 8th fl., 600 Hollins St., Baltimore, MD 21201.

IMPORTANT: If Item 21 is marked on Item 18, show any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8602948

031133

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
SUE BEALLE ROWE						January 28, 1986				4:23 AM	
1c. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Female		Caucasian		May 23, 1893		92		YRS			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. BALTIMORE CITY OR COUNTY OF DEATH		St. Mary's County MD			
MD		USA									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Leonardtown		St. Mary's Hospital				Homemaker		Own Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MD		Pr. Geo.		Accokeek		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15849 Livingston Rd. 20607			
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
John		William	Bealle	Sallie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (16b. NO OR UNKNOWN)		17a. SOCIAL SECURITY NO.		17b. INFORMANT		17c. ADDRESS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		218-24-0942		daughter		Sallie Grimes same as 13					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident (cont)</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21b, PART I OR PART II)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY/DETOWN		COUNTY		STATE	
22a. I certify that (i) (this hospital) attended the deceased from <u>7/2/85</u> to <u>1/28/86</u> that (ii) (we) last saw the deceased alive on <u>1/27/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) see the body after death.											
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS									
James C. Boyd, M.D.		Leonardtown, Md. 20650									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		1/30/86		Arlington National		Arlington				VA	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Huntt Funeral Home, Waldorf, MD				JAN 29 1986							



028019

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows an injury, or other traumatic event, the medical examiner must be informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 0 2 9 4 9					
REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MARY			ELIZABETH			RUSSELL			January 19, 1986					1:00 PM	
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1923			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County		MD.				
10. CITY OR TOWN OF DEATH Leonardtown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		20622				
13a. STATE Md.			13b. COUNTY St. Mary's			13c. CITY OR TOWN Charlotte Hall			13d. INSIDE CITY LIMITS? NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE General Delivery				
14. FATHER'S NAME FIRST Carroll			MIDDLE Spalding			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE		LAST Carroll				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-18-8288			17. INFORMANT W Carol J. Collins, Charlotte Hall, Md.			ADDRESS Rt. 2, Box 19		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										cardio Respiratory failure					
DUE TO, OR AS A CONSEQUENCE OF (b) cerebro vascular accident															
DUE TO, OR AS A CONSEQUENCE OF (c) with (R) Hemiparesis.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ventricular Arrhythmia. hypertension															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Adintha Patil, M.D.										DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/22/86	
22d. PHYSICIAN'S NAME Adintha Patil, M.D.										22e. ADDRESS Leonardtown, Maryland 20650					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/22/86			23c. NAME OF CEMETERY OR CREMATORIAL Trinity Memorial Gdns.			23d. LOCATION CITY OR TOWN Waldorf, Charles		STATE Md.				
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.										25a. DATE REC'D. BY REGISTRAR 1/24/86		25b. REGISTRAR'S SIGNATURE John D. Mattingley			

9000

023034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10. FULTERSON DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-form permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical certificate must be signed by the attending physician.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												86	02950	
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
LILLIAN JOHANNA SAMUELS						January 15, 1986			10:30A.M.					
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR April 9, 1899			6. AGE (IN YEARS LAST BIRTHDAY)					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7d. IF UNDER 1 YEAR MONTHS DAYS					
8. CITY OR TOWN OF DEATH Leonardtown			9. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier			11b. KIND OF BUSINESS OR INDUSTRY Star Route Box 74					
12a. STATE Md.			13b. COUNTY St. Mary's			13c. CITY OR TOWN Leonardtown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Star Route Box 74		
14. FATHER'S NAME FIRST MIDDLE LAST Louis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Elizabeth McGee											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT Edna S. Morse Same as 13e.								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes hours		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			18b. DUE TO, OR AS A CONSEQUENCE OF Acute Myocardial Infarction			18c. DUE TO, OR AS A CONSEQUENCE OF Hypertensive C-V Disease								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from <u>1985</u> to <u>1986</u> , that (1) <u>last</u> saw the deceased alive on <u>1986</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (2) I <u>certified</u> did not view the body after death.												22c. DATE SIGNED 1/17/86		
22b. SIGNATURE James P. Jarbee, M.D.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS Leonardtown, Maryland 20650								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/18/86			23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.			23d. LOCATION CITY OR TOWN Baltimore, Baltimore, Md.					
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.						25a. DATE REC'D. BY REGISTRAR JAN 21 1986			25b. REGISTRAR'S SIGNATURE John P. Johnson					
DHMH - 16 60M 7/84 (VRA 15, 4)														

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• 100 •

Aug. 1, 1986, 10001 SBA

009188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy filed in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this section.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 6 0 2 9 5 1						
REG. NO.																
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			GEORGE EDWARD SMITH						January 3, 1986			8:10 PM				
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS					
Male			Black		June 10, 1902			83			MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.			USA						St. Mary's County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Leonardtown			St. Mary's Hospital						Electrical Work & Plumbing							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE						
13a. STATE Md.			13b. COUNTY St. Mary's		13c. CITY OR TOWN Ridge			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Gen. Del. 20680					
14. FATHER'S NAME FIRST John			MIDDLE Henry		LAST Smith			15. MOTHER'S MAIDEN NAME FIRST Jane			MIDDLE LAST Campbell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			214-18-8268			Viola Smith			Same as 13e.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Metastatic carcinoma of colon						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										DUE TO, OR AS A CONSEQUENCE OF (b)						
										DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION Dec. 30 1985			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 2000						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 3 1986</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>Jan 3 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Youngsik Moon, M.D.</i>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22c. DATE SIGNED 1/4/86																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
Youngsik, Moon, M.D.			Hollywood, Maryland 20636													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/7/86			23c. NAME OF CEMETERY OR CREMATORIAL St. Peter Claver			23d. LOCATION CITY OR TOWN Ridge			COUNTY St. Mary's		STATE Md.		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.										25a. DATE REC'D. BY REGISTRAR JAN 7 1986			25b. REGISTRAR'S SIGNATURE <i>BP</i>			
DHMH - 16 60M 7/84 (VRA 15, 4)																

THEORY OF THE STATE

### ...and too many

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 0 2 9 5 2  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

016117

1-  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST  
John

MIDDLE

LAST

Walter Spicer

2a. DATE KNOWN  
OF DEATH  
ESTIMATED  
MONTH DAY YEAR  
Jan. 4 1986 M

2. SEX

Male

4. RACE

Black

5. DATE OF BIRTH

MONTH DAY  
March 6, 1939

YEAR  
46

6. AGE (IN YEARS  
LAST BIRTHDAY)

IF UNDER 1 YR.  
MONTHS DAYS

IF UNDER 24 HRS.  
HOURS MIN.

7c. DATE  
PRONOUNCED  
DEAD  
MONTH DAY YEAR  
Jan. 4 1986 M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED  
WIDOWED  
DIVORCED

NEVER MARRIED

□

□

□

9. BALTIMORE CITY OR COUNTY OF DEATH  
St. Mary's

MD.

10. CITY OR TOWN OF DEATH

Patuxent River

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Patuxent River Naval Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS  
OR INDUSTRY

13a. STATE

Md.

13b. COUNTY

St. Mary's

13c. CITY OR TOWN

Ridge

13d. INSIDE CITY LIMITS?

YES  NO

13e. STREET ADDRESS

Rt5, Box 7 20680

14. FATHER'S NAME

James

MIDDLE

LAST

Spicer

15. MOTHER'S MAIDEN NAME

Marion

MIDDLE

Cecilia

LAST

Smallwood

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

217-34-2310

17. INFORMANT

Marion C. Spicer

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DOUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

Probable Myocardial Infarction 5cc

(b)

Cardiomegaly

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES  NO

21a. EXTERNAL CAUSE WAS  
UNDERLYING  OR  
CONTRIBUTING  CAUSE OF DEATH

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE  NOT WHILE   
AT WORK  AT WORK

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on  
death resulted from  Natural causes  Accident  Suicide  Homicide  Undetermined manner

Autopsy  Inspection  Inquiry  and in my opinion

ACTUAL  
SIGNATURE *Wm D. Boyce Jr.*

M.D. MEDICAL EXAMINER

DATE  
SIGNED 1/6/86.

EXAMINER'S NAME  
(TYPE OR PRINT)

*Wm D. Boyce Jr.*

ADDRESS

Leonardtown, Md.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE  
1/9/86

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION  
CITY OR TOWN

COUNTY STATE

St. Ignatius St. Mary's Md.

Burial

Mt. Zion Meth. Cem.

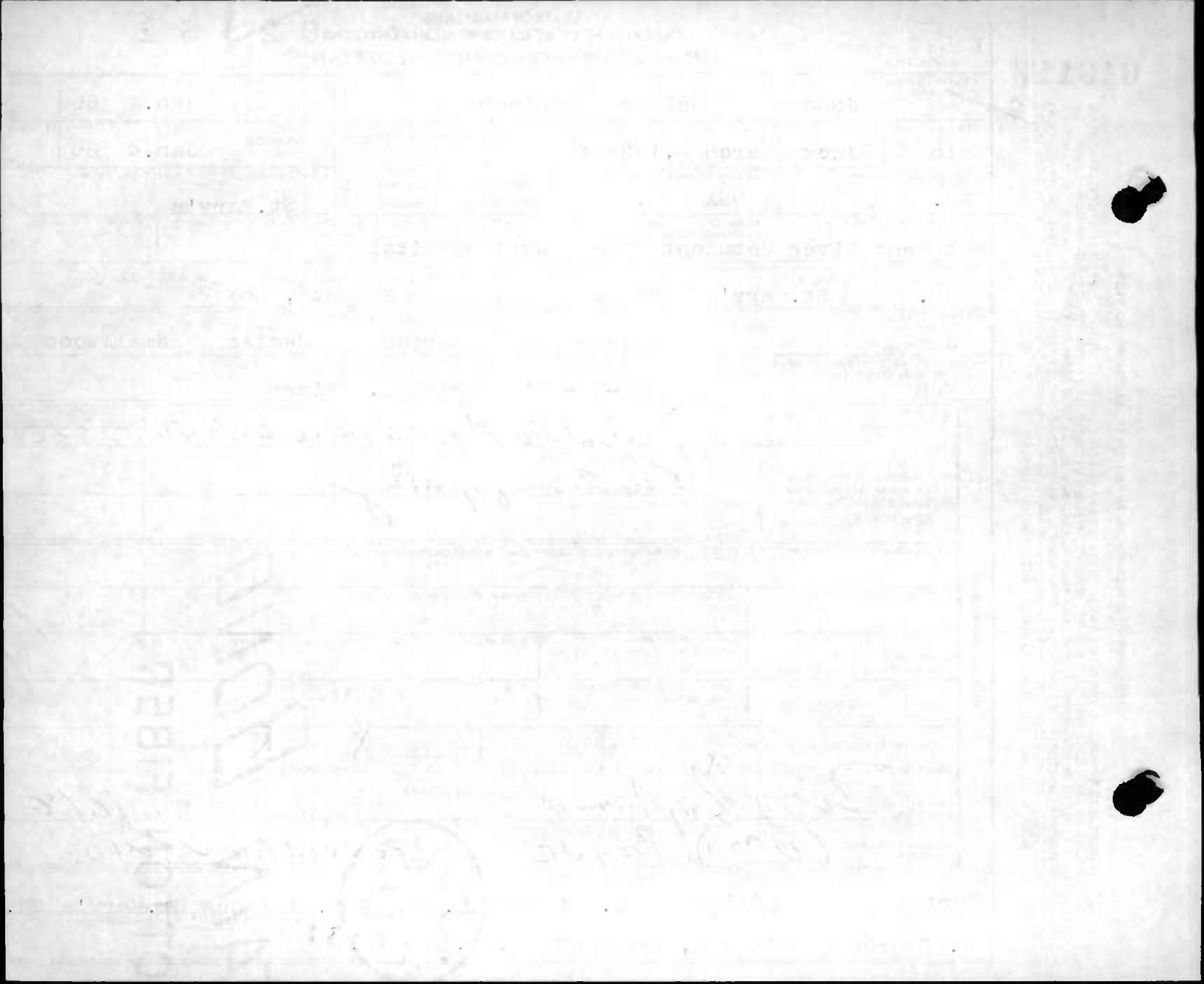
JAN 13 1986

24. FUNERAL DIRECTOR  
NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

W. Clarke Mattingley, Leonardtown, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

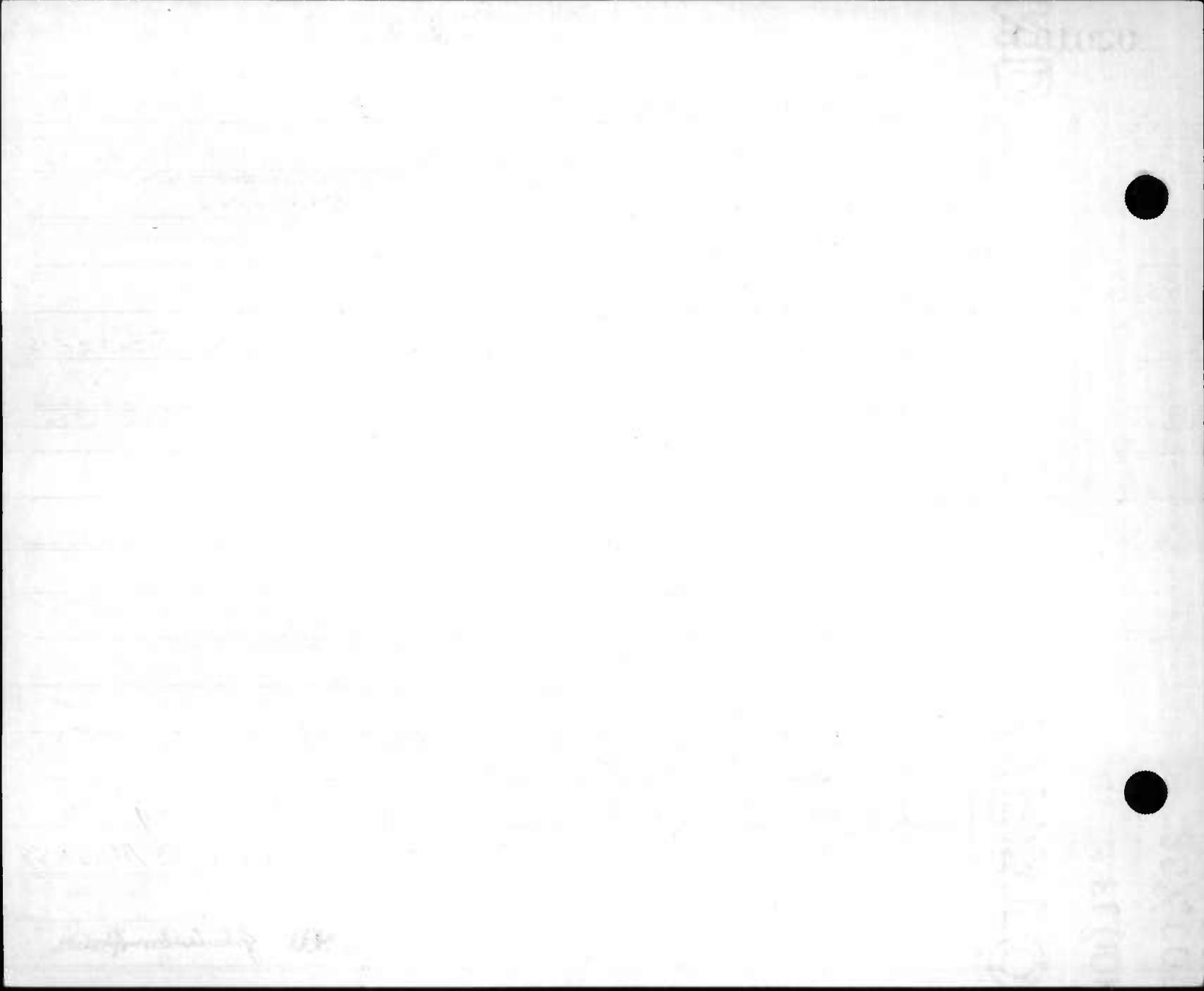
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please give to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND					DEPARTMENT OF HEALTH AND MENTAL HYGIENE					CERTIFICATE OF DEATH					REG. NO. 02953				
1 - FOR STATE REGISTRAR																			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
STOLTZFUS, MARY S							S	9			JAN	9	1986	12 45					
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS						
F			W		MONTH JAN DAY 6 YEAR 1985		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTHS 2			DAYS 16 HOURS 45 MIN 45						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
MARYLAND			USA		ST MARY'S														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
LEONARDTOWN			ST MARY'S Hospital					HOUSEWIFE			20629								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
MARYLAND			ST MARY'S		RURAL CHARLOTTE HALL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Gen. Del.									
14. FATHER'S NAME			FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
SAMUEL BENJAMIN STOLTZFUS					HANNAH			NONE			PARENT								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, (b), and (c).)			PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												ANENCEPHALIC BIRTH DEFECT				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			DUE TO, OR AS A CONSEQUENCE OF (b)																
			DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/9/1986 to 1/9/1986, that (I) (we) last saw the deceased alive on 10/30/1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																			
22b. SIGNATURE Roy Guyther, M.D.			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 1/19/86										
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. Roy Guyther, M.D.			22f. ADDRESS Rt 3 Box 4 MECHANICSVILLE MD 20659																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Jan. 9, 1986			23c. NAME OF CEMETERY OR CREMATORIAL Hurtzler Cemetery			23d. LOCATION CITY OR TOWN Charlotte Hall, St. Mary's, MD			23e. COUNTY STATE							
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley			ADDRESS Leonardtown, Maryland			25a. DATE REC'D. BY REGISTRAR JAN 16 1986			25b. REGISTRAR'S SIGNATURE Julie Anderson										
DHMH-16 20M (VRA 15, 4) 7/78																			



037093

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, 4, 10, 11, 12, 13 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-100. BURIAL TRANSIT PERMIT, PAGES 1 AND 2, WHICH SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1- STATE REGISTRAR		2a. DATE KNOWN OF EST- DEATH MATED										2b. HOUR			
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		<input checked="" type="checkbox"/> MONTH		DAY		YEAR			
JOSEPH		EMERICK		TROSSBACH				<input checked="" type="checkbox"/> JAN. 29, 1986				0722A			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. DATE MONTH DAY YEAR		2d. HOUR	
MALE	WHITE	FEB. 7, 1932		53 yrs.						JAN. 29, 1986				M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED		<input type="checkbox"/>		ST. MARY'S						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PATUXENT RIVER		NAVAL HOSPITAL										ELECTRONICS TECH. CIVIL SERVICE			
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN DAMERON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS TROSSBACH ROAD STAR ROUTE BOX 85 20628							
14. FATHER'S NAME FIRST LOUIS		MIDDLE T.		LAST TROSSBACH		15. MOTHER'S MAIDEN NAME FIRST CAROLINE		MIDDLE NORRIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -----		16c. INFORMANT ANN TROSSBACH		16d. ADDRESS TROSSBACH ROAD, BOX 85 DAMERON, MARYLAND 20628									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable Myocardial Embolism</i> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) <i>5 sec</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 sec</i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Boyd</i>														TITLE (SPECIFY) M.D. <i>D.P.T.</i> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		WILLIAM D. BOYD, II, M.D.										ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-1-86		23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S CATHOLIC RIDGE		23d. LOCATION CITY OR TOWN ST. MARY'S MARYLAND		25a. DATE REC'D. BY REGISTRAR FEB 04 1986		25b. REGISTRAR'S SIGNATURE <i>Joha Davidson-Pender</i>					
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		ADDRESS													
DHMH - 17 (VR A15 ME (5))															

Constitution

042078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/tranquill permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial. Removal of important if item 21 is marked on item 18. Shows any injury or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					86	02955
					REG. NO.	
1. FOR STATE REGISTRAR	FIRST VIRGINIA	MIDDLE JARRELL	LAST YATCHUM	2d DATE OF DEATH January 31, 1986	MONTH YEAR	2b HOUR 3:00 P.M.
3 SEX FEMALE	4 RACE WHITE	5 DATE OF BIRTH MONTH AUGUST YEAR 26, 1922	6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.			
10. CITY OR TOWN OF DEATH Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b KIND OF BUSINESS OR INDUSTRY			
13a STATE MARYLAND	13b COUNTY ST. MARY'S	13c CITY OR TOWN COMPTON	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE ST. CLEMENTS SHORES 20627		
14. FATHER'S NAME FIRST CHARLES	MIDDLE L.	LAST JARRELL	15 MOTHER'S MAIDEN NAME FIRST ANNA	MIDDLE	LAST CARTER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b SOCIAL SECURITY NO. W.W.II	17. INFORMANT ST. CLEMENTS SHORES JOHN G. YATCHUM, COMPTON, MARYLAND 20627	ST. ADDRESS			
18. CAUSE OF DEATH: Enter only one cause per line for Part 1b and 1c PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Metastases to liver Metastatic carcinoma Metastatic carcinoma of rectum colon						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b Metastases to liver						
19a DATE OF OPERATION 8/1/85	19b CONDITION FOR WHICH OPERATION WAS PERFORMED Surgical obstruction	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2				
21d INJURY OCCURRED	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a I certify that (i) this hospital attended the deceased from 1/31/86 to 1/31/86, that (ii) we last saw the deceased alive on 1/31/86, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (iii) we did not view the body after death.	22b SIGNATURE A. Samadi, M.D.	22c DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) A. Samadi, M.D.	22e ADDRESS Leonardtown, Maryland 20650	22f DATE SIGNED 2-1-86				
23a BURIAL, CREMATION, REMOVAL SPECIFY CREMATION	23b DATE 2/1/86	23c NAME OF CEMETERY OR CREMATORIAL HUNT CREMATORIAL	23d LOCATION CITY OR TOWN WALDORF, CHARLES, MARYLAND			
24 FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.	25a DATE REC'D. BY REGISTRAR FEB 05 1986	25b REGISTRAR'S SIGNATURE Julia T. Brinsfield, Jr.				



029142

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

02956

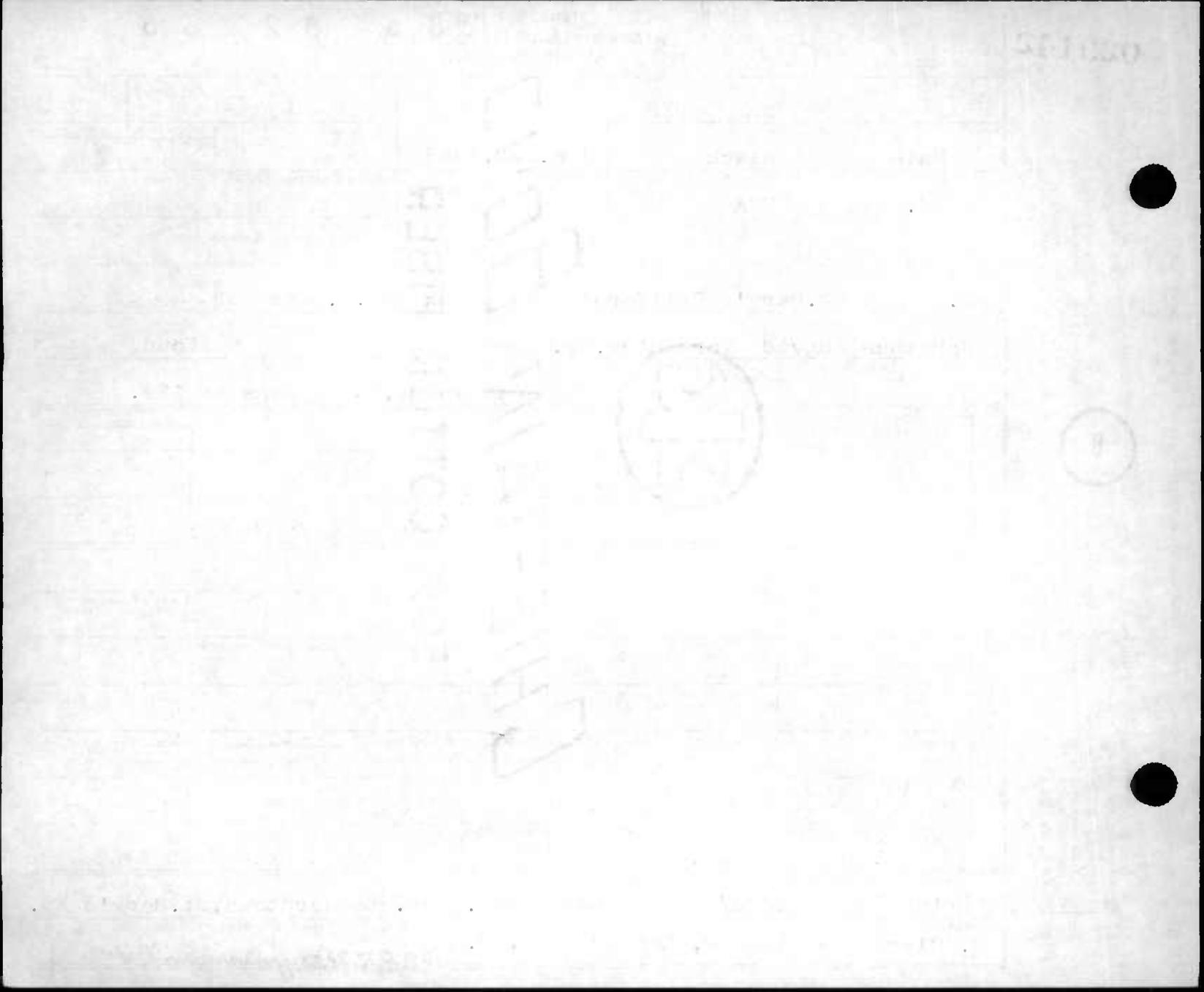
1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR							
JONATHAN DAVID YORKSHIRE						January 22, 1986			4:00P M								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
Male		Black		Jan. 22, 1986					2 YRS.								
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Md.		USA				St. Mary's County MD.			Leonardtown		St. Mary's Hospital						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
13a STATE Md.		13b COUNTY St. Mary's		13c. CITY OR TOWN California		Rt. 2, Box 632 20614											
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST							
Johathan		David		Yorkshire, Sr.		Emma				Young							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c INFORMANT		ADDRESS		17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No		None		Emma Young,		Same as 13e.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)												Cardiorespiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Immediately																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (c) Preterm birth at 18 weeks.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f.													
22a. I certify that (I) (this hospital) attended the deceased from 1-22-86, 1986, to 1-22-86, 1986, that (I) (we) last saw the deceased alive on 1-22-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 1-28-86.					
22c. SIGNATURE Mohamed Lafeer MD.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Lafeer, M.D.		22e. ADDRESS Leonardtown, Md. 20650		23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/86		23c. NAME OF CEMETERY OR CREMATORIAL Charles Mem. Gdns.		23d. LOCATION CITY OR TOWN Leonardtown, St. Mary's Md.	
24. FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JAN 27 1986		25b. REGISTRAR'S SIGNATURE Julie L. Lafeer											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 0 2 9 5 7  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

031142

FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST  
Mary Lillian Young

2a. DATE KNOWN  MONTH DAY YEAR 2b. HOUR  
OF ESTI-  
DEATH MATED  Jan. 25, 1986 M

3. SEX 4. RACE 5. DATE OF BIRTH 6. AGE (IN YEARS  
MONTH DAY YEAR LAST BIRTHDAY)  
Female Black Mar. 13, 1911 74 YRS.  
IF UNDER 24 HRS.  
MONTHS DAYS HOURS MIN

2c. DATE PRONOUNCED  
DEAD Jan. 25, 1986 M

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY?  
Abell, Maryland USA 8. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH  
St Mary's MD.

10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
Leonardtown, St Mary's Hospital 12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS  
OR INDUSTRY  
Home maker Self

13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS?  
Maryland St Mary's Abell YES  NO  13e. STREET ADDRESS  
Gen. Del. 20606

14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
Richard Woodland Annie Carter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT  
No 212 32 0733 Joseph A. Tyer 3502 ADDRESS 25th Place  
Temple Hills, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART 1 DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last. *Inflatable Myocardial Infarction* sec  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c) *ASCVS* yrs.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY?  
YES  NO

21a. EXTERNAL CAUSE WAS  
UNDERLYING  OR  
CONTRIBUTING  CAUSE OF DEATH 21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE  NOT WHILE  AT WORK  AT WORK 21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.) 21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy  Inspection  Inquiry  and in my opinion  
death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL  
SIGNATURE *Tom D. Boyd* M.D. *1/27/86* TITLE (SPECIFY)  
MEDICAL EXAMINER

EXAMINER'S NAME  
(TYPE OR PRINT) *Tom D. Boyd* M.D. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) Burial 23b. DATE 1/29/1986 23c. NAME OF CEMETERY OR CREMATORIAL  
Sacred Heart 23d. LOCATION  
CITY OR TOWN Bushwood, St Mary's, Maryland  
COUNTY STATE

24. FUNERAL DIRECTOR  
NAME *W. Clarke Mattingley* ADDRESS Leonardtown, Maryland 25a. DATE REC'D. BY REGISTRAR  
25b. REGISTRAR'S SIGNATURE *1/29/1986*

31180

